TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Nueva Vida Behavioral Health

Respondent Name
Ace American Insurance Co

MFDR Tracking Number
M4-15-0189-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
September 15, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Nueva Vida obtained preauthorization for psychiatric diagnostic interview exam on 06/09/2014. Carol Gilmore issued the certification #1076333 with a date range of 06/09/2014 thru 08/30/2014."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Preauthorization was not obtained as required by the healthcare network. Therefore, the provider is not entitled to reimbursement."

Response Submitted by: ESIS, P.O. Box 31143, Tampa, FL 33631-3143

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 5, 2014 June 12, 2014 June 16, 2014	96152 96152 90791	$800.00	$733.29

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - W-9 Unnecessary treatment with peer review
   - 18 – Duplicate claim/services

Issues

1. Were the services prior authorized?
2. Is the carrier liable for the disputed services?
3. What is the applicable rule pertaining to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states, "Preauthorization was not obtained as required by the healthcare network." This claim pertains to code 90791 – Psychiatric diagnostic evaluation and 96152 – Health and behavior intervention, each 15 minutes, face-to-face, individual. Review of the submitted documentation finds;

   a. Notification from Coventry Workers Comp Services dated June 11, 2014

   b. Notification of Certification, Procedure – Mental Health Testing (2 hours), Initial Psychiatric Diagnostic Interview (3 hours)

   c. Quantity 1, 1, Diagnostic, Doctor

   d. Date of Service 06/09/2014 – 08/30/2014

   e. On behalf of E.S.I.S. the requested treatment referenced above has been reviewed by Coventry Workers' Comp Services, and has been determined to be medically necessary.

   Based on the above, the Division finds the service provided on June 5, 2014 was not authorized. The remaining services on June 12, 2014 and June 16, 2014 were authorized. The carrier's position is partially supported. 28 Texas Administrative Code 134.600 (p) (7) requires, "all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;" As this requirement was met for the services provided on June 12, 2014 and June 16, 2014 these services will be reviewed per applicable rules and fee guidelines.

2. 28 Texas Administrative Code 134.600 (c) states,

   The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

   (1) listed in subsection (p) or (q) of this section only when the following situations occur:

   (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

   (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

   Furthermore, 28 Texas Administrative Code 134.600 (h) states,

   Except for requests submitted in accordance with subsection (g) of this section, the insurance carrier shall either approve or issue an adverse determination on each request based solely on the medical necessity of the health care required to treat the injury, regardless of:

   (1) unresolved issues of compensability, extent of or relatedness to the compensable injury;

   (2) the insurance carrier's liability for the injury; or

   (3) the fact that the injured employee has reached maximum medical improvement.

28 Texas Administrative Code 134.600 (l) requires, "The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued."

The carrier is liable for dates of service June 12, 2014 and June 16, 2014 as the requestor provided evidence of preauthorization prior to providing the healthcare on these dates where the services was deemed "medically necessary," and the prior authorization cannot be withdrawn.

3. 28 Texas Administrative Code 134.203 (c) states,

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   The maximum allowable reimbursement will be calculated as follows;

   - Procedure code 90791, service date June 16, 2014. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 3 multiplied by the geographic practice cost index (GPCI) for work of 1 is 3. The practice expense (PE) RVU of 0.63 multiplied by the PE GPCI of 0.916 is 0.57708. The malpractice RVU of 0.11 multiplied by the malpractice GPCI of 0.816 is 0.08976. The sum of 3.66684 is multiplied by the Division conversion factor of $55.75 for a MAR of $204.43 at 3 units is $613.29.
   - Procedure code 96152, service date June 5, 2014, was not authorized no additional payment recommended.
   - Procedure code 96152, service date June 12, 2014. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.46 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.46. The practice expense (PE) RVU of 0.08 multiplied by the PE GPCI of 0.916 is 0.07328. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.816 is 0.00816. The sum of 0.54144 is multiplied by the Division conversion factor of $55.75 for a MAR of $30.19 at 4 units is $120.76. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $120.00.

4. The total allowable reimbursement for the services in dispute is $733.29. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $733.29. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $733.29.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $733.29 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		October , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.